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COMMON CONDITIONS OF THE FEET OFTEN CONFUSED WITH FUNGUS INFECTION

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SINCE THE SKIN is limited in its mode of expression many conditions of the feet resemble and are often mistaken for fungus infections. This has practical importance since the treatment and prognosis are entirely different.

Before considering the various entities it will be of value to state briefly some pertinent facts regarding Dermatophytosis. The causative fungus stripped of its botanical descriptive terms is a microscopic plant. It is undifferentiated and has neither stems, roots nor leaves. Cultured on Sabouraud's medium the various fungi may be easily differentiated. Occasionally it may be necessary to subject the growth to fermentation tests and microscopic examination for precise identification. The culturing has practical significance as will be discussed.

In the average case of suspected Dermatophytosis of the feet, particularly in private practice, it may not be feasible or necessary to culture every case. However, where the response is negligible cultures are often required and may be the *sine qua non* in diagnosis.

The four most common fungi attacking the feet¹ are *Monilia Albicans*, *Epidermophyton Inguinale*, *Trychophyton Gypseum* and *Trychophyton Purpureum*. The first three respond to a multitude of remedies; the latter with difficulty and frequently not at all.

At times this infection with the *Trychophyton Purpureum* fungus is the most rebellious to treatment of all superficial mycoses seen in this part of the country. Here our favorite treatments may fail. Although cures are possible^{2,3} especially in localized and early cases it may be frequently recalcitrant particularly when well-entrenched.

Furthermore, it may spread to the hands or become generalized and thereby present a most distressing and chronic condition^{4,5}. Fortunately, it is the less common type but, unfortunately, it is not rare. Where infection with other fungi more commonly give rise to marked inflammatory lesions such as erythema and vesiculation in addition to fissuring and maceration, the *Trychophyton Purpureum* is more apt to be well-margined, less erythematous and without vesiculation. The absence of visible vesicles is a persistent feature⁶. Scaling may be present in all.

If the dermatosis does not respond to fungicides, if repeated cultures do not show a pathogenic fungus then other conditions should be considered, especially if some of the clinical characteristics now to be described are present.

Pustular Bacterid

The most common condition misdiagnosed as Dermatophytosis is Pustular Bacterid^{7,8,9,10,11}. Although many descriptions have been given in the literature, the disease must be repeatedly seen to be fully appreciated. The palms may be involved with the soles, but the latter may be involved alone. There may be superimposed mycotic, bacterial or contact dermatidides. In its early uncomplicated stage there are clusters of deeply-seated pruritic clear vesicles which may progress to cloudiness. These erupt in showers and new lesions may be appearing while old ones are involuting. Most important, fungi cannot be isolated. Nor do they respond to fungicides. Unless secondarily infected, the lesions are usually sterile bacteriologically. The co-existence of a focus of infection in teeth, tonsils, etc. is believed to be the causative factor. Aureomycin and other antibiotics internally may eradicate but more often will control the infection. It is prone to be chronic, being associated with remissions and exacerbations unless distant foci are found and eliminated.

Contact Dermatitis

Contact Dermatitis (*Eczema Venenata*, *Dermatitis Venenata*) may occur as a primary entity or

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be superimposed on another dermatosis. The dyes or finishes in stockings or socks, the dyes, etc. in shoe leathers¹²⁻²⁰ and medicaments used are obvious offenders. Although exceptions may be noted, the overwhelming number of cases show, in addition to other areas, some involvement of the dorsa of the feet and contiguous parts of the toes which are not the more usual sites for Epidermophytosis. The lesions are generally diffuse, erythematous and vesicular and well-margined. Furthermore, although almost any lesion may be pruritic, these are more intensely so and are also associated with burning and marked discomfort.

The wearing of white cotton stockings, changing the make of shoes, treatment of the condition with bland medication such as Boric Acid compresses and Lassar's Paste and the subsequent amelioration or disappearance of lesions point to the diagnosis of Contact Dermatitis. Patch-tests with suspected substances will aid in establishing the diagnosis. The recurrence when exposed to suspected contactants presents further evidence that we are dealing with a Contact Dermatitis.

Hyperidrosis with Symmetric Lividities

Just how much increased localized sweating has to do with the furtherance of fungus infection is problematic, there being a difference of opinion. Some believe that sweat is fungicidal, others that it promotes infection. It would seem that in intertriginous areas²¹ such as submammary, inguinal, intergluteal and interdigital areas, the maceration and irritation helps fungi to flourish but this does not necessarily apply to the soles. Possibly much depends on the PH of the sweat which in turn is dependent on the diet, amount of sweat secreted, the care taken thereof and the degree of evaporation²².

At times hyperidrosis is associated with symmetric Lividities²³. There are dead white areas^{24, 25}, well-demarcated, sensitive to the touch and appearing in areas where shoes gave rise to pressure and friction on macerated skin. Others²⁶ have described a similar picture but the areas were bluish-red. The elimination of pressure points and application of 15% Aluminum Chloride in Alcohol has proven helpful.

Psoriasis

Although Psoriasis is more frequently a generalized condition, it may occur only on the palms^{27, 28} and/or soles.²⁹ When confined only to the soles it is almost invariably mistaken for Dermatophytosis. On examination the lesions are usually erythematous and scaly and at times deeply fissured. However, more careful observation reveals the erythematous part to be parchment-like, smooth and devoid of vesicles. The silvery scales referred to

in the literature have been over-emphasized and offer scant help to the examiner. Furthermore, the scales may undergo oxidation and have a brownish hue. Histological examination, although usually not necessary, is characteristic. No fungus can be cultured from these lesions. They cannot be cured with fungicides although response may be imagined because of the removal (partial) of the scales by almost any greasy medication. The treatment is the same for Psoriasis on any other part of the body which, incidentally, could benefit (to state it mildly) from some hitherto undiscovered "magic drug."

Atopic Eczema

Although adolescent and adult Atopic Eczema is seen usually on other parts of the body such as the cubital and popliteal fossae or face and hands, it may be evident only on the dorsa of the feet³⁰ and the toes. The primary lesion is a papule or a number of papules forming lichenified areas. Although there is no vesiculation in uncomplicated cases, there may be weeping, crusting and exudation because of scratching and infection³¹. In making a diagnosis a multitude of factors must be considered. There may be a history of infantile Atopic Eczema. Usually the patient has been seen before and has had the usual episodes of remissions and flareups with characteristic lesions on other parts of the body. Again no fungi can be demonstrated with repeated cultures. Fungicidal remedies *aggravate*. Contactants employing the usual procedures can be ruled out. Hay Fever and/or Asthma may be elicited in patient or family. Some believe that a food is the incriminating factor but this in adult cases, is usually wishful thinking which all too frequently lacks confirmation. Emotional factors may play a part, but the question always arises whether the neuroses is causing the condition or whether the pruritic and unsightly condition is making the patient neurotic. It would seem that patients start with a monovalent sensitivity, progress to a polyvalent sensitivity and finally to a non-specific one. While students debate the issue and proudly proclaim spectacular cures in exceptional and isolated cases, the patient learns to be grateful for a little relief. Usually this is afforded with bland topical applications such as Burrow's Compresses, Plain Lassar's Paste and x-ray cautiously and judiciously administered.

Lichen Chronicus Simplex or Discoid Neurodermatitis

Lichen Chronicus Simplex of Vidol may be confined to the ankle and contiguous parts of the foot. Other sites of predilection are wrists, inner parts of the thighs, nuchal, post-auricular and sub-occipital areas. The patient often gives a history of

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TRYCHOPHYTON GYPSEUM
Culture—On Sabouraud's Media



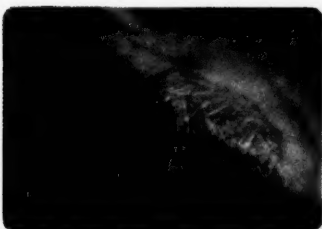
TRYCHOPHYTON PURPUREUM
Culture—On Sabouraud's Media



MONILIA ALBICANS
Culture—On Sabouraud's Media



EPIDERMOPHYTON INGUINALE
Culture—On Sabouraud's Media



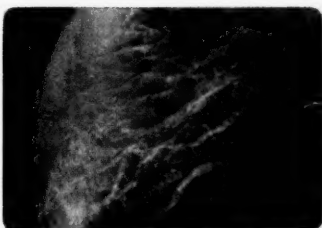
PSORIASIS



ATOPIC ECZEMA



LICHEN CHRONICUS SIMPLEX (Ankle)



Infection on sole caused by:
TRYCHOPHYTON PURPUREUM



PUSTULAR BACTERID (Sole)



LIVIDITIES



CONTACT DERMATITIS



DERMATOPHYTOSIS (Heel)



DERMATOPHYTOSIS



DERMATOPHYTOSIS (Sole)

PHYSICAL EXAMINATION IN INDUSTRY AS A CANCER CASE-FINDING PROCEDURE*

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THE PASSAGE of compensation laws, the first of which was enacted about forty years ago, led industry to use physical examinations as an aid in selecting people for employment. This was important because it had the effect of broadening medicine's value to industry and industrial workers, attracting the favorable attention of management and establishing physical examinations as a valuable function of industrial health programs.

At first the examinations were for selection of new employees only and they were little more than superficial inspections, seeking out hernias, deformities and other rather obvious physical impairments and handicaps potentially compensable later on. Now they are highly perfected procedures for a variety of special purposes contributing to better health, safety on the job and longer years of employment. These special purposes are: (1) occupational placement as well as selection of new employees; (2) replacement after sick leave and prolonged absence from work; (3) diagnosis of occupational diseases; (4) estimation of disability in claims for compensation; (5) health maintenance (usually called periodic examinations); (6) case finding in disease-control programs; and (7) consultations with employees.

For each of these purposes there is a particular examination routine, and rarely does it cover all parts and functions of the body. In employment, selection and placement it is designed for recognition and estimation of handicaps and capacities, as well as knowledge and skills. Examinations after absence from work may be limited to questions, with perhaps a casual physical inspection, depending on the length of absence and the cause of it. The extent of such an examination is left to the judgment of the physician.

In the diagnosis of occupational disease, the examination is one that will show the presence,

absence, or improvement of the disease process arising out of employment. It, too, may be limited, seeking only evidence of a specified occupational disease known to be possible through an employment exposure. In some instances, it may be restricted to laboratory tests only, and for disability estimations, it may concern only the part or parts affected.

The health examination is to assist employees in keeping well and employable, and to aid them in obtaining early treatment from their family physicians when that is needed. The extent to which a physician carries on such an examination will be suggested to him by the symptoms offered or the employee's record of complaints but it is usually rather complete. It is made periodically, sometimes annually, but more frequently every other year, and sometimes not that often.

Case-finding examinations are limited, and may consist only of laboratory work. They are often furnished by agencies outside of industry. Within the last two or three years, however, some industrial physicians have made special efforts in the early detection of diseases of the heart, cancer of the lung, and other diseases of a non-occupational nature but nevertheless productive of disability which severely impairs working capacity.

It appears, then, that routine physical examinations in industry do not offer unusual opportunities for cancer detection. Skin and other superficial malignancies may be found in one fashion or another as in private practice. Cancers of occupational origin are carefully sought after and usually found early. But, generally speaking, an industrial physical examination cannot give sufficient attention to the areas most frequently involved in cancer—the stomach and prostate in men, and the breast and cervix in women. The industrial examination is, however, contributing increasingly to the early recognition of lung cancer through use of chest x-rays as a routine feature of the examination.

Despite the limitations of examinations in industry, there are three ways by which early cancer detection can be promoted in industrial medical departments: (1) through the fine relationship which exists between industrial physicians and the

* Presented at the Fourth Annual Cancer Conference of Physicians under the auspices of the Rhode Island Medical Society, held at Providence, October 17, 1951.

employees served by them, (2) by an industrial adaptation of certain features of the Hillsdale (Michigan) Plan for cancer detection, and (3) by use of health education.

Employee-Physician Relationship. The opportunities of industrial physicians to counsel with employees are enjoyed to a like extent by few physicians outside of industrial practice. It is not unusual, for example, for employees to make one or two visits to the medical department each month. In a plant employing 10,000 people this custom would therefore provide the plant physician and his staff with 10,000 to 20,000 employee contacts each month, each one of which is of a personal and sometimes of an intimate nature. Through the record which is kept of services of this kind, it becomes quickly evident that certain employees are suffering from conditions that require close study and perhaps active treatment by their family doctors. For example, one man comes in with symptoms of indigestion, and asks for soda bicarbonate. When this has happened a certain number of times, the nurse or physician who has seen him decides that a study of the case is in order. It is studied, x-rays are taken, and a malignancy is found. An operation is obtained early enough so that prospects for a cure are reasonably good. Such was an actual case, yet various routine examinations received by the patient failed to indicate what was occurring, while the record led to a study that did. This case illustrates what is happening in industrial medical departments, and how regular services lead to the discovery of malignancies. It must be admitted that procedures of this kind do not rate as early detection procedures.

The Hillsdale Plan for Cancer Detection. Perhaps industry's contribution through its medical routine is sufficient, but the success of the Hillsdale Plan for tumor detection suggests that even greater successes can be obtained in industry if the plan can be integrated with industrial medical services. The purpose of the Hillsdale Plan, established by a group of practicing physicians in Hillsdale County, Michigan, is to encourage the people of the County voluntarily to request cancer examinations from their family physicians. The examination, given by the physician in his office at the regular office fee, is a complete physical examination with special attention to those sites where cancer is most frequently found. It includes whatever supplemental services the physician believes are indicated, such as x-ray, biopsy, and laboratory studies. The names of the patients enrolling together with a report of the findings, are sent to the local health department, thus providing the basis for a cancer register.

Of course, this would mean that every industrial medical department is potentially a cancer-detect-

tion center. There are, however, certain cases, especially in women, where the plant physician cannot go so far as the family doctor would. There would be too much criticism if, for instance, every woman in the plant had a vaginal examination or an examination of the breast. Industrial physicians cannot do this sort of thing, but they can follow up leads brought about by studies of the records and requests for service or advice from the employees. If they are not in a position to make the examinations themselves, they can send the employees to their own physicians, as provided in the Hillsdale Plan, and probably that would be more desirable anyhow. In that way industrial medicine becomes a feeder for practitioners who are participating in cancer detection. Incidentally, this same routine results in fairly early discovery of other chronic diseases, such as diabetes, heart disease and tuberculosis.

Health Education. There is a third way in which industrial medical departments can be helpful in the promotion of cancer control, and that is through education. Dr. Joseph S. Devitt, of Milwaukee, for example, has discussed cancer in an employees' magazine, and I believe that his contribution is sufficiently important to justify a complete quotation:*

"In this year alone 200,000 persons are, with cold statistical certainty, going to die of one single disease — cancer.

"Not a very pleasant thing to think about, is it? Can't something be done?

"My answer is 'Yes, something can be done — maybe.' And the 'maybe' depends in large part on each one of us who may become a victim.

"At least half the folks who will die of cancer this year failed to help themselves in one of these ways: (1) they failed to heed their symptoms of cancer; (2) they failed to have the courage to tell their physician of the symptoms; or (3) they failed to learn the symptoms.

"'But,' you might say, 'We're not doctors. How can we recognize the symptoms of cancer?'

"Here's how — by simply remembering that any of the following may mean cancer:

1. A lump anywhere in the body, especially if it is growing.
2. A sore which does not heal.
3. Continued indigestion or loss of appetite.
4. A change in bowel habits.
5. Bleeding from any body opening, such as the rectum, etc.
6. Chronic cough, hoarseness.
7. Difficulty in swallowing.

"If you will look back at the paragraph coming just before this list of seven cancer symptoms, you'll see that I said these symptoms may mean

*GM Folks, 13:10 (Sept.) 1950.

cancer. Other diseases besides cancer may cause any of these symptoms — and this is important to remember because it is the job of the doctor, once he knows about the symptoms, to search carefully and thoroughly and find out what diseases are causing them.

"You've got to cooperate with him on this job. Tell him about your complaints within a week or two after they begin. This may mean the difference between life and death for you.

"Far too many still labor under two very mistaken ideas about cancer. Their first mistaken idea is that a diagnosis of cancer amounts to a death warrant. Their second mistaken idea about cancer is that it sneaks up on a victim and develops to the stage where it can't be cured before it produces symptoms.

"Let's debunk these two phony impressions right now. Many cancers are being cured every day by operation, x-ray or radium — but not by anything else. Keep away from the salves, colored lights, or grandma's vinegar and milk poultices — they won't help you a bit. Let your common sense take hold so you can look at the disease clearly; cancer practically always, in its curable stages, produces one or more of the seven warnings. And take cheer in knowing that if cancer is diagnosed early, it can be cured. But only you can give the doctor the chance to make an early diagnosis. Keep alert regarding the symptoms. It's up to you."

Industrial medical examinations are highly specialized and can only be used for the early detection of cancer through the incidentals and by-products coming out of them. It is suggested, however, that the day-to-day contacts in a plant between doctor and employees bring out leads which direct the physician's attention to possibilities of the early diagnosis of malignancies. Employees may then be examined by the plant physician, but probably will be referred to their own family physician or others who are participating in the cancer-detection program. Education as carried on by many industrial physicians can be most helpful in attracting employees needing early diagnosis to consult physicians in the plants, whereupon they can be referred to their own doctors for subsequent study and treatment.

COMMON CONDITIONS OF THE FEET OFTEN CONFUSED WITH FUNGUS INFECTION

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the lesions appearing *after* scratching³². In this pruritic plaque there are erythematous discrete papules at the periphery with confluence towards the center. Concomitant scaling, thickening and

exaggeration of the skin markings are evident. Some cases are equally well described as Atopic Eczema and the clinical picture may even be simulated by some varicose eczemas. The condition is believed by many to be akin to, "nervous heart," "nervous stomach" and "nervous headache" but here the *locus minoris resistentiae* is the skin. X-ray cautiously and wisely given may control or cure. Covering with Elastoplast Bandage after application of 2% Gentian Violet almost always gives relief. A psychiatric approach may be productive of results³³.

Less Common Dermatoses

A word about the less common dermatoses. Keratosis Palmaris et Plantaris and Keratoderma Punctata symmetrically involve the palms and soles, although one or the other may be spared. Endocrine Keratoderma may be confined to the feet and may simulate other common dermatoses. However, proven cases have not appeared in this study. Syphilis confined to the soles is rare but must be considered in the differential diagnosis. Pompholyx is much more frequently seen on the hands. Dermatophytids of the feet secondary to Dermatophytosis of the hands are much less commonly seen than the reverse, that is, Dermatophytids of the hands secondary to Dermatophytosis of the feet. Arsenical Keratoses are much less frequently seen now because the Arsenicals have mostly been replaced with more efficacious remedies. There are conflicting opinions regarding the exact status of Pustular Psoriasis³⁴, the discussion of which would contribute little to this paper.

Conclusions

The more common Dermatoses resembling Dermatophytosis of the feet have been discussed. In their uncomplicated stage, they may be distinguishable with proper tests and attention to details of Morphology and History, provided the effects of superimposed scratching, secondary infection and over treatment have been removed.

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CONCLUSIONS FROM TEN YEARS INVESTIGATION OF THE CASE WORK AMONG DERMATOSIS PATIENTS

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THE GENERAL PRACTITIONER and public health physician are to be commended for contributing to and keeping abreast of practically every new phase of medical science. Their broad knowledge of the treatment of even the lesser known diseases is remarkable as compared with what was known by their predecessors of only a few decades ago.

Yet, in the field of dermatosis it is quite another matter. The cause and the treatment of too many skin diseases remains unknown these days to too many general practitioners and public health physicians. This is true despite the fact that statistics show that more than half of the people with minor to chronic skin diseases never consult a dermatologist. They remain away from the general practitioner in this regard mainly because in many instances the physician has shrugged off simple cases of dermatosis, such as acne, with the statement, "You'll grow out of it."

While in itself this may be true, yet the physician—by an indifferent attitude—is contributing unwittingly to the growth of a vast proprietary medicament field, which promises those with minor skin eruptions all sorts of commercial cures.

Conclusions arrived at following 10 years investigation of the case work among dermatosis patients in the health units of Boston, plus work while in the U. S. Navy Medical Corps and at the Massachusetts General Hospital, and a diligent reading of the literature by today's dermatologists, reveals that more and better specific therapy must be made available to the general public.

When the physician does not know the proper therapy for minor skin diseases he should refer the patient to a dermatologist and not shrug off the condition. Over and above this, the general practitioner and the public health physician should have a working knowledge of the causes and specific therapy of all forms of dermatosis.

The diagnosis either of a specific cutaneous disease or of the type of morphologic lesion predomi-

nantly present is needed for proper therapeutic management. In other words the proper diagnosis is necessary for the proper treatment. The history remains extremely important; environment, diet, contact factors, psychogenic factors, and other factors which may be important should all be investigated. Systemic disease with its frequent manifestations on the skin should be investigated both by careful questioning and by means of a thorough physical examination. The careful weighing of all these factors may contribute much to the local and systemic management of the disease and the patient.

The choice of topical measures is determined by the morphologic features of the lesions and the most acute lesion determines the type of treatment to be given.

For the acute, oozing, vesicular cutaneous lesions wet dressing of Burrow's solution, boric acid, or potassium permanganate are advised, as well as soothing baths of a colloidal type. For the subacute types of dermatoses with only slight crusting, shake lotions and mild soothing ointments may be given.

The alarming increase of skin allergies among persons of all ages can be attributed in large part to some types of proprietary medications aimed at replacing the dermatologist. In their advertising claims they promise to cure various sorts of dermatosis from simple acne to aggravated stages of psoriasis.

This rise in skin allergies has been noted especially at public health clinics and hospital outpatient departments. A large percentage of those whose conditions have worsened after use of these unscrupulous products seek aid at these centers, hoping to escape the fee of the dermatologist. They refuse to evaluate the fact that had they sought treatment by a dermatologist originally instead of following the directions "on a bottle or can" not only would their dermatosis be more controlled, but they would have been spared the effects of skin allergy, which frequently results from self-medication.

An investigation of 587 case reports at public health centers and out-patient departments in Boston shows that 73 per cent of those following the self-medication plan increased the severity of their

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disease and 38 per cent developed chronic or acute skin allergies, in addition, by self-medication with harmful medicaments.

This is particularly true among those suffering from acne vulgaris. Since it is a "disease of adolescents," too often parents tend to dismiss the dermatosis with the statement, "don't worry, you'll grow out of it."

In the meantime, of course, the acne progresses, and there is subsequent scarring, and frequently a severe psychic reaction which may prove to be more difficult to treat than the pustules themselves.

In a vain attempt to rid themselves of their disfigurement, they start reading "the ads." There are numerous patent medicines which claim in their advertising "to do the trick."

The ingredients in some proprietary medications may be of a high type. But there are too many varying factors in each case of dermatosis to guarantee a cure in all cases.

What most adolescents fail to understand is that when one or more remedies is tried the following possibilities should be considered to prevent the remedy from disagreeing with the patient's comfort or the morphologic manifestation of the disease.

Naturally, the layman cannot take into consideration certain scientific possibilities, and bad reactions set in. The patent medicine causing the disease aggravation does not, in its literature, take into consideration these possibilities:

1. The morphologic factors are not considered in each case.
2. The treatment can be too stimulating.
3. Hypersensitivity or idiosyncrasy to the medicament may develop.
4. The ingredients of the medicament were not properly prepared for each case.
5. The suggestion of frequent daily washings of the face, back and chest—while sage advice in itself—can create inflamed skin allergies which aggravate the acne by use of improper soap.

Many advertisements for these medicaments fail entirely in considering the general type of treatment for acne. The general systemic measures provide for dietary instruction as follows:

The patient can only obtain from a dermatologist assurance that there is no known dietary factor that can be considered paramount at the time of his original visit. He is instructed by the dermatologist to withhold all forms of chocolate, cocoa and excessive pastries from his diet for three to four weeks and then to add back those foods previously restricted and note any untoward effect. In other words, if he improves while on the diet and he

becomes much worse when the foods are again taken, these foods are considered to have some etiologic significance.

In the same matter, use of other foods such as milk and dairy products, nuts and excessively fatty foods may be restricted.

Use of oral preparations containing iodides or bromides should be restricted although this restriction does not include use of iodized salt which should be maintained, particularly in the Central States.

Numerous vitamins have been suggested as a treatment for acne. For most patients the administration of vitamin A, 50,000 units or more daily, may be recommended. Its use is indicated especially when the follicular hyperkeratotic lesions are associated with the acne.

Small doses of desiccated thyroid also are indicated in the more severe types of acne that have been unresponsive to the more conservative types of treatment. However, use of this preparation should be discontinued if tremor, palpitation, irritability, restlessness, sleeplessness or loss of weight is noted. The basal metabolic rate should be determined frequently.

Local treatment comprises, in part, the care of the skin and scalp and proper instructions should be given concerning such care. The patient should be instructed that picking, manipulation, and punching the skin for expression of the comedones, is absolutely contraindicated, since this can frequently cause secondary infection and scarring. With the presence of numerous pustules too active cleansing of the face with the use of wash cloths and complexion brushes should be avoided. Nevertheless, frequent washings are indicated to remove the excess oil and to assist in removal of the comedones. The frequency of washings depends entirely on the amount of oil on the patient's skin, and, therefore, the face may have to be washed frequently in order to keep the skin relatively dry. The scalp should be shampooed at least once a week and, when much seborrhea either of the dry or oily type is present, the scalp should be shampooed more frequently. Cosmetics may be used but should be removed thoroughly at night, and the use of face creams should be avoided. Sunlight or ultraviolet light is frequently of marked benefit to patients with acne.

Acne surgery, in that the comedones are expressed by the physician or the pustules are incised and drained, may be done once or more times a week. The frequency depends upon the activity of the process.

IRRITANT ACTION OF SOAP: It is not our purpose to discuss all phases in explanation of

the irritant action of soap on the skin. The two following phases are, however, pertinent.

Most studies incriminate the fatty acids, especially certain types and amounts of the various fatty acids.

Conclusions are that the saturated fatty acids of lower molecular weight (caproic, caprylic and capric acids, and lauric present in the mixed fatty acids of coconut oil, predominantly used in the manufacture of soap) are primary cutaneous irritants. As the molecular weight increases above that of capric acid irritant action becomes less, but such action is exerted as the Ph of the skin rises above normal. This action was less apparent with stearic and with palmitic acids.

The prolonged exposure to alkali in many soaps impairs the function of the skin to neutralize alkali and predisposes to dermatitis.

Our investigation revealed that about 62 per cent of all soaps caused some sort of skin allergy on 37 per cent of 587 cases reviewed by us. Frequent washings of the face, back and chest caused us to discontinue these soaps and to seek a more effective agent.

Patients with acne vulgaris must bathe these areas at least three times a day with soap and warm water. Those found allergic to soaps cannot follow this prescribed treatment or a skin allergy results.

Even more serious is the predicament of patients with exceptionally oily skin who should wash their faces from four to five times daily. Thirty-five per cent of the cases were unable to shave without aggravation of the acne, or the production of a skin allergy. Soaps containing alkali, plus the scraping action of razor blades, were factors determined to have caused the spreading of the skin eruptions.

Investigation showed that dermatologists at the Massachusetts General Hospital and other noted hospitals around the United States prescribed with success the use of soaps in which the medicament was emulsified with Triethanolamine and Stearic Acid.

Effect of medicated soaps in general: When the skin is washed with soap, a saponification of the fat on the skin-surface takes place, by the addition of water. The fat, however, is not limited to the skin-surface, but occurs especially also in the hair-follicles and glands of the skin (more particularly so in seborrhea and similar conditions) so that the medicinal substances, through the emulsifying of these fats, are made to penetrate deeper, into the hair-follicles as far as the fundus; hence, there occurs a deep action into the skin, under employment of medicated soaps.

A dynamic action ensues, through irritation of the blood-vessels, a stimulation of the absorption.

Uña assumes, besides the absorptive action, also the production of anaemia in the corresponding skin segments, when soap is employed.

This intense surface action, with the deep effect upon the sweatglands, is of great importance in certain skin diseases, such as acne.

It is better to know only a few prescriptions and to know them well than to have a long list of therapeutic remedies without knowledge of their indications, properties or characteristics. Some newer ointment bases of oil in water type, and also liquid detergents, are now available. In some cases these are better tolerated by the skin and render therapy more beneficial.

However the author has had wide success and recommends a cake soap formula used exclusively at the Massachusetts General Hospital and other hospitals for cleansing the skin, known as Cuticura Soap.

The soap combined with Cuticura Ointment is the only agent employed by the author which produced not one case of skin allergy and aided in the clearing up of the acne. Because of this remarkable record, the author investigated the composition of these products and learned the following: The soap is medicated by the addition of the Cuticura Ointment, emulsified with Triethanolamine and Stearic acid. The ointment contains natural unbleached petroleum products with the naturally occurring complicated sulphur compounds. The base is saturated with U.S.P. sulphur and added oxyquinoline, an antiseptic material. In the use of the soap, this antiseptic material is reduced considerably, and will not conform to the Department of Agriculture tests for germicides. For this reason the soap is not labeled "antiseptic" although it does have a decided inhibitory action. This inhibitory action is enhanced by the presence of certain essential oils, phenol and chlorophyll.

This formula which is designed to give a satisfactory soap with a very low capric and lauric acid content, hence low irritability, is as follows: Pure soap base, 81.27 p.c. (10 p.c. soft soap—90 p.c. hard soap): selected pine resin 3.88 p.c. glycerin 0.60 p.c.: blended essential oils 1.25 p.c. (Eugenol—16.63 p.c.) Cuticura ointment, 4.00 p.c. Formula for ointment: Unbleached mineral oil 34.65 Gm., (sulphur .35 p.c.); Unbleached petrolatum 42.57 Gm. (sulphur .048 p.c.); Unbleached mineral wax 19.80 Gm.; Beeswax (Natural) 1.99 Gm.; Pine Oil 0.40 Gm.; Rose Geranium Oil 0.17 Gm.; Vegetable Chlorophyll 0.07 Gm.; Phenol, U.S.P. 0.16 Gm.; Precipitated sulphur 0.50 Gm.; Oxyquinoline 0.05 Gm.

These agents did not produce a single skin allergy, despite the fact that more than 60 per cent of those tested developed skin allergies with other

continued on next page

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agents following frequent daily usage. Regardless of the frequency of use of this type of medicated soap, the emollient properties and the soap fat combination protects against developing of an allergy. Such topical remedies as Cuticura Ointment and Soap may be applied with safety and reasonable local success daily. But the cooperative effect of the specialist or physician must be employed for general treatment and wider success.

Two general principles of therapy must be remembered at all times, and these are the following: When in doubt as to the treatment to be given, give the mildest and most soothing type of therapy first. In this regard it is well to treat only a small area first, to observe possible untoward reactions and to observe the benefit gained in this area before proceeding to treat large areas of involvement. By this method it is possible to use two or more preparations in small areas as "Trials." Another principle of therapy to remember is the following: Avoid changing the therapy when that previously used or now in use is providing relief. Treatment should be changed only when the dermatologic manifestations have become worse or stationary.

Summary

In an analysis of 587 cases of acute and chronic skin diseases from March, 1941, to April, 1951, at Boston Health Department Units and outpatient departments and while in the United States Navy Medical Corps, the following conclusions were reached:

1. General practitioners and public health physicians must become more aware of the causes and specific therapy for various skin diseases to aid dermatologists combat the rise in the number of skin allergy patients caused by the promiscuous use of "cure-all" preparations.
2. Seventy-three per cent of the cases studied who followed the self-medication plan increased the severity of their dermatosis and 38 per cent developed chronic or acute skin allergies by self-medication with harmful medicaments aimed at replacing the dermatologist.
3. Our investigation revealed that about 62 per cent of all soaps caused some sort of skin allergy on 37 per cent of the cases studied by us. Frequent washings of the face, back and chest caused us to discontinue these soaps and seek a more effective agent.
4. These agents called Cuticura did not produce a single skin allergy, although more than 60 per cent of those tested developed skin allergies with other agents following daily usage.
5. The general public must be educated to seek medical instruction for all forms of dermaiosis. The general public must be warned against self-medication for any form of dermatosis.

HOW SHOULD THE MEDICAL RECORDS LIBRARIAN MEET THE NEEDS OF THE HOSPITAL?*

— *The Medical Records Librarian's View* —

E. LOUISE SEYMOUR, R.R.L.

The Author. E. Louise Seymour, R.R.L., of Boston, Massachusetts. Chief Record Librarian, Massachusetts General Hospital; 2nd Vice President and Secretary, Council on Education, American Association Medical Record Librarians.

HOW SHOULD the medical records librarian meet the needs of the hospital? Without good, accurate and complete medical records she can't. And how to get these good, accurate and complete medical records is almost the sixty-four dollar question! So much has been said and written about that problem that I won't go into it in detail here. So much more has been *thought* about those individuals who contribute to this problem, but those thoughts had better *not* be expressed here!

Assuming that our records are as perfect as possible let us see how they can be used to serve the hospital. From them we can compile statistical reports which provide a basis for the preparation of operating budgets, for the distribution of expenses, and for the calculation of average income and costs per unit of service rendered. By use of the Medical Audit the work of the individual doctor can be evaluated, and the work of various services can be evaluated by the information recorded for the Hospital Discharge Analysis.

Records are used for medical research, one of their primary functions after the care of the patient. A clever medical records librarian can stimulate interest in such research and give a great amount of help to the doctor in his studies. It is she who should familiarize herself with the various methods of making material available, in order that her Record Committee and Administration may decide upon the best manner of recording these data. It may be by manual indexing or by the more elaborate punched card method. Either system will depend upon the requirements of those planning research. Should a doctor request some item not ordinarily included in the diagnostic file, it is a simple matter for the medical records librarian to

add a column to the card and collect the information requested. Not much work for her, but a real service to the physician.

By indoctrination of interns, student nurses, and others, the medical records librarian can improve the *standards* of the records, thus meeting a definite need of the hospital. Most of the hospital personnel consider the record room as a dumping ground for everything that has to be filed! Orientation and demonstration of the functions of the department instills in them a greater appreciation of the importance of medical records and all that is involved in their upkeep.

If the medical records librarian has any part in admitting procedures she will investigate and encourage the use of time savers in speeding up the time element between what often seems a long journey for the patient—from front door to bed. Saving of time in this office may also result in increased efficiency for those other departments whose work originates in the admitting office.

Every hospital has one outstanding need—money! Every hospital has a common problem—lack of it! Can a medical records librarian hope to save money for the hospital when her department is constantly expanding? This annual expansion requires expensive equipment, and labor for moving records back. It would seem almost impossible to cut expenses under such circumstances, but actually it can be and has been done. The latest system of filing medical records according to their Terminal Digits has accomplished this feat. By this method of filing, it is no longer necessary to purchase costly file cabinets, as each year a certain number of records are made inactive to make room for new admissions. Inactives are then stored in transfer cases which cost one seventh as much as a regular file. All cabinets are used to capacity at all times and the annual shifting-back process is eliminated. Because of a more even distribution of work, more duties can be added to the ordinarily dull job of pulling and filing, which not only provides greater variety for the clerks, but in some instances has made possible a reduction in staff. Such economy, plus the increased efficiency of the

continued on next page

*Presented at the Annual Meeting of the Rhode Island Association of Medical Librarians, at Providence, May 9, 1951.

system is reflected not only in the medical records department, but throughout the hospital.

Dr. Bodemer has suggested that medical records librarians be "open minded to new thinking." That to me is a "must" in meeting the needs of the hospital. We should keep abreast of the changing trends in equipment, experiment, and study each new product from the cost as well as efficiency angle. There is no excuse for having a typist struggle along with an old, battered machine that operates something like a cement mixer, when an electromagnetic typewriter can increase production by at least 20%. The machine may seem expensive at first, but with such an increase in production it pays for itself in a very short time.

Up-to-date equipment has a powerful effect on the *morale* of the workers, too. No employee can give of her best if her tools are poor, or if she is physically uncomfortable while working. A contented worker is a valuable worker, and that contentment stems from the department head who makes sure that her staff is well taken care of. Increases in salary when deserved are a good investment in morale, as are the little things that count so much—interest in the individual and her problems, attractive hours, vacation when *she* wants it, if possible, encouragement, help when her work falls behind, understanding, and patience. All of these factors help to establish a feeling of loyalty and of belonging to the hospital, and to stimulate interest in the job.

Each job should be reviewed periodically to see if some step can be eliminated, thus saving unnecessary motions on the part of the employee. Production records kept on the income and output of work not only give a clear picture of the employee's ability, but show when an employee is overloaded or not receiving enough work to warrant full time on that job. These records also stimulate interest and a spirit of competition among the employees. In the training of personnel they should be thoroughly oriented, and taught not only *how* to do the work, but *why* it is being done; that each duty plays a small, but important part in the care of the patient either at present, or in the future through medical research. The confidential nature of the medical record must also be stressed and each employee made to feel that guarding this information is her responsibility.

The medical records librarian must be prepared to meet emergencies—not only by adequate coverage in her department in cases of illness or other absence, but by planning ahead for more serious emergencies, namely, disaster. By proper organization and administration she can give an invaluable service to the hospital by handling the clerical work involved in admitting and starting records for emergency admissions. Her forethought in work-

ing up a simple "disaster form" which can be filled out quickly, will greatly expedite the admitting procedure, and should assure an adequate record of the injuries with a minimum of confusion. A crew of phlegmatic clerks can be trained for this in advance and kept on telephone call in the event of disaster. When the situation has eased and the real emergency is over, these forms may be checked against the name file and placed in the records of those patients already known to the hospital. This material may prove of value in the future for study of treatment of such cases.

Suppose the disaster were caused by bombs, and the hospital partially destroyed! A horrible thought, this, but not an impossibility in view of the present world situation, and an emergency for which some preparation should be made. Records can, and should be saved if possible, although priority naturally would go to patients, hospital equipment, drugs, etc. Some hospitals have made plans for evacuation and for setting up temporarily in safer areas. The moving of filing cabinets seems a tremendous job, but by systematic planning, adequate provision can be made. Predetermination of the number of years of records to be preserved, and an estimate of the amount of floor space required will save confusion during the process of moving. The master file will be required, as well as blank records and folders. If plenty of space is available it would be desirable to move the diagnostic file for safekeeping. Valuable mechanical equipment should go, too, although records and indexes should be given priority. The preservation of these records would not only meet the needs of the hospital immediately following the crisis, but the records would still be intact for medical research in the future.

Another duty of the medical records librarian is to encourage others to enter this fascinating field. With over 6000 hospitals in the country and only about 2500 registered record librarians, she would be meeting the needs, not only of her own hospital, but of others as well—a service to humanity.

If the medical records librarian is of pleasing personality, pleasantly persistent (and I stress the word *pleasantly*), accurate, co-operative with all with whom she comes into contact, progressive, patient, efficient, and above all, endowed with a good sense of humor, she has won half the battle in meeting the needs of the hospital.

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THE TAXATION ISSUE

THE ACTION of the House of Representatives in reversing its position on the debatable revenue act of 1951 is certain to have repercussions for many months to come. To the average citizen the question basically is how much additional money will be taken from his wages. The average worker has become somewhat hardened to this matter of increased taxes, but what is the limit? And what average citizen has a knowledge of the manner in which expenditures by the Federal government are justified?

It is significant that in the debate on the second conference report the statement was made on the floor of the House that "the Government incurs obligations, and this Congress has been authorizing them." It is as simple as that.

Great publicity is given the debate on the final tax legislation and it is pointed out — too late — that you do not economize on a tax bill. You have to save money and cut out waste at the time the authorization bills are before Congress.

Thus we are to infer that an extravagant, and a wasteful organization is to be condoned. The bills have been incurred, however right. The bills must now be paid. Hence argument over the revenue tax bill is superfluous. The second conference report adopted by the Congress highlighted the fact that the increase in tax in the first bracket of individual income-tax rates is reduced from 11½ per cent to 11 per cent. On a \$2,000 income this will save the family head \$1.40; on a \$3,000 income there will

be the magnificent reduction of \$2 on the bread winner's whole year's salary.

What kind of skulduggery is this to perpetrate on the American people? Who is going to have the courage to fight for the reduction of waste, excessive taxation, and deficit spending? The House made what it thought a great gesture in turning down the first conference report on taxes. But it was only kidding the public, for it knew that it had already appropriated the money, and the bill collector was at the door waiting his payment.

There were members of the Congress who spoke courageously on what are the real issues behind the additional tax measure, and we report some of their comments made on the floor of Congress on the debate of the first conference report —

Here's Mr. Reed of New York —

Mr. Speaker, we are not dealing today with just another revenue bill. We are not debating the merits of minor tax provisions.

No; and make no mistake about this; we are engaged today in a head-on clash between two basic policies — between two diametrically opposed principles — and the issues can be simply stated:

Shall we continue to spend ourselves into bankruptcy and tax the people into poverty, or shall we reduce Government spending and preserve the principles of our Republic?

continued on next page

Shall we yield further ground to socialism or shall we hold fast to freedom and progress?

Shall we defy communism abroad but surrender our liberty at home?

These are the real issues involved in this conference report on the Revenue Act of 1951, and these issues should not become beclouded by false and pious talk of curbing inflation, of balancing the budget, or of paying-as-we-go, because this new tax increase bill will do none of these. The terrible fact is that excessive and uncontrolled Government spending is on the loose, and the bottom of the American tax barrel has already been reached.

Now Mr. Curtis of Nebraska —

I shall vote against this conference report . . . we have reached the point, and far beyond, of irresponsible spending and taxation . . . By better and more efficient collection of taxes we can improve the Treasury by a billion dollars. We should also rescind appropriations heretofore made by enough billions to balance the budget and save this economy.

And Mr. Martin of Massachusetts . . .

There is more at stake than the burden of taxes. If this tax bill becomes law, approximately one third of the income of the American people will be going to Government — Federal, State, and local. The history of monarchies and the Communists and Socialist dictatorships has demonstrated conclusively that no people can be free when the citizen has less and less of his own money to spend and the Government spends more and more of it for him.

And Mr. Vorys of Ohio,

Mr. Speaker, in a lot of ways I hate to vote for this conference report; it contains a number of inequities and it lays a heavy burden on everybody. But this Congress has already appropriated, with and without my vote, more money than will come in under our present tax laws. I am opposed in principle to deficit spending; we ought to approximate pay as we go, even in a period like this. We cannot do it with this year's spending without another tax bill. This bill is more than \$4,000,000,000 below the President's request. That will be a deterrent to extravagance in spending . . .

And Mr. Philbin of Massachusetts,

I cannot and will not support this tax bill. In my opinion it is a wholly unnecessary and unconscionable raid upon the meager earnings of the rank and file of the American people who would be compelled under its provisions to pay the overwhelming portion of its huge levies.

I am strongly of the view that one of the great and crying needs of the hour is insistence by the Congress of the meticulous elimination of waste,

extravagance, and improvident spending by the military and every other branch of this Government. We must scrupulously inspect and justify every single item of the budget to insure economy and efficiency and conserve our great national resources as against the day when we may have to mobilize and use them for the defense of the Nation.

THE UAW AND THE AMA

According to the UAW (United Automobile, Aircraft and Agricultural Implement Workers of America — CIO) the doctors of America were all wrong in paying dues to their own American Medical Association which were to be used in part to carry forward a national education campaign against socialism in this country, particularly the socialization of medicine. The AMA assessment, and the educational campaign, drew harsh and critical comment from the labor press, and particularly the publications of the UAW.

But how much did the AMA spend in its campaign in 1950, and for that matter in operating its entire program?

And how much did the United Automobile Workers turn over to Mr. Reuther and his organization to distribute in order to further the efforts of the UAW-CIO?

1950 was the first year in which members of the American Medical Association were called on to pay membership dues. By the end of the year \$2,655,785 in dues had been collected, and by the end of March, 1951, an additional \$183,617.50 was reported. Of the dues collected \$2,346,955.58 was allocated to the National Education Campaign, and this sum, with the unexpended balance of \$676,145.45 reserved at December 31, 1950, and \$70,284.50 of the 1949 assessments paid in 1950, covered the cost of the campaign.

But — the campaign costs included a half million dollars given for the establishment of the American Medical Education Foundation to aid the medical schools of this country!

The income of the American Medical Association to carry on its tremendous organization for the advancement of medical science, and the improvement of the health of the people of this country, amounted to \$5,503,500.46 in 1950.

Fellowship and membership dues (less the allocation to the educational campaign) contributed only \$379,148.42 of this operating expense — less than 7% of the total operating cost! Periodical subscriptions and advertising provided the remainder of the funds utilized for administration of the various councils and bureaus and related activities of the Association.

How much money did the UAW handle during the same period of time to carry out its organiza-

tion activities, including its propaganda for socialization programs?

According to the audit report of May 31 of this year the United Automobile Workers — and bear in mind this is but ONE of the major labor groups in the country — listed total receipts for the twelve months ending May 31, 1951 of \$14,239,279.13. Of this amount more than 8½ million dollars comprised the General Fund created from per capita tax, initiation fees, work permits, etc.

The disbursements from this General Fund for officers salaries and the administration of various departments which include such divisions as Editorial (\$389,809), PAC (\$120,434), Radio (\$39,801), Washington Office (\$53,529), General and Administrative (\$2,467,825), amounted to a grand total of \$4,910,270.01.

We have, therefore, just ONE of the large union groups — representing only a million of the workers of this country — spending for its general operation only six hundred thousand dollars less than the American Medical Association spent in the same period of time for its organization, including the printing and distribution of all its scientific medical journals!

And against the AMA's special assessment to carry forward its national education, including the \$500,000 for outright grants to medical schools, the United Automobile Workers organization received as special strike assessment and taxes from its members nearly 5 million dollars!

The next time you hear any comment about the American Medical Association and its activities, including its effort to educate the American public to the dangers of socialism, just remember the figures we have cited above.

NATIONAL RECOGNITION

The Association of American Physicians and Surgeons represents the most vigorous group within the profession at this time concerned with the socio-economic aspects of medical practice. The organization has been outspoken on national issues, and has implemented the work of the Washington office of the AMA with its reporting of Congressional proposals and the necessity for action upon them by medical societies and physicians individually.

It is with pride therefore that we report that at its annual meeting in Indianapolis during the past month the Association chose as its president-elect Dr. Charles L. Farrell of Pawtucket.

Leadership in medical organizations is of vital importance to the entire Profession today. Certainly we who know Charlie Farrell intimately, and who have admired his unusual ability to do many things, and to do them exceptionally well, hail his choice as a future head of the American Association

of Physicians and Surgeons. His wide range of activities in Rhode Island, and in particular for the Rhode Island Medical Society, fit him for greater tasks with the national association.

HOSPITAL ACCREDITATION

Less than a year ago we commented editorially on the action of the College of Surgeons in turning to the American Hospital Association as the sole body to succeed it as the accrediting authority of the hospitals of the country. Our contention was that the work was a task that properly belongs in whole or in part to the American Medical Association.

It is with pleasure that we noted the recent announcement of the American Medical Association that a plan for a joint commission has finally been established, composed of 18 members, six appointed by the AMA, six by the American Hospital Association, and three each by the American College of Surgeons and the American College of Physicians.

This new commission will be financed by the constituent organizations on a basis proportionate to their representation on the commission. Their task will be to formulate standards relating to hospital accreditation, to establish the type and scope of inspections to be made under the program, to assign responsibility for hospital inspections to the several participating organizations, and to award certificates of accreditation to qualifying hospitals.

Once again we have a demonstration of cooperative action in working out an agreement satisfactory to four major organizations in the health field, but of greater significance, satisfactory for a continuing inspection to keep our American hospitals on the high plane which guarantees to the people of this country the finest hospital care available anywhere in the world.

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DISTRICT MEDICAL SOCIETY MEETINGS

NEWPORT COUNTY MEDICAL SOCIETY

A meeting of the Newport County Medical Society was held on May 23, 1951. President Henry Brownell called the meeting to order at 9:00 p.m.

The minutes of the previous meeting were read and approved.

A communication was received from Dr. Norman MacLeod, Health Commissioner, requesting action of fluoridization of water supply.

Dr. Frank Logler, reporting for the Delegates, gave a report on the bills pertaining to alcoholics in the Providence legislature.

The application of Dr. Bronie Apschaga was referred to the Censors.

Dr. Ceppi suggested that a committee be formed to approve contributions of the individual doctors to various organizations. This was discussed but no action was taken.

The Society went on record as approving fluoridization of local water supply.

The speaker for the evening, Florence Murray, gave an enlightening talk on the Constitutional Convention.

The meeting adjourned at 10:30 p.m.

Respectfully submitted,

OSMOND GRIMES, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held September 20, 1951, at the Nurses' Auditorium, Memorial Hospital.

The meeting was called to order by the President, Dr. Kieran W. Hennessey, at 12:15 p.m.

The minutes of the June meeting were read by the Secretary and accepted.

An application for admission to the Association from Dr. Albert Foster was presented. This was referred to the Standing Committee.

The application of Dr. Edward J. Butler was accepted by unanimous vote.

Dr. Earl J. Mara reported on the last meeting of the House of Delegates.

The President then introduced Dr. Edwin Dunlop, of Fuller Sanitarium, who spoke on Shock Therapy. He stated that lower voltage machines with milder treatments are more in use now and are helping to shorten mental illness and time of hospitalization. He discussed this treatment in de-

pressions, schizophrenia, neuroses, barbiturate poisoning, and involuntional melancholia. The non-convulsive treatment was then demonstrated on a live case by Dr. Lindbergh, also of Fuller Sanitarium. This illustrated the better control of treatment and the finer adjustments of the machines now available.

Attendance was 37.

Luncheon was served.

The meeting adjourned at 1:20 p.m.

Respectfully submitted,

HRAD H. ZOLMIAN, M.D., *Secretary*

WOONSOCKET DISTRICT MEDICAL SOCIETY

A meeting of the Woonsocket District Medical Society was held on September 11, 1951 at the Howard Johnson restaurant on the Louisquiset Pike, North Smithfield, Rhode Island.

The minutes of the last meeting were read and accepted.

Mr. Saunders of the Wyeth Company presented a film on the Teleclinics of the American Academy of General Practitioners. It was interesting as well as instructive.

The Society went on record as thanking Dr. Dupre for the wonderful party and entertainment held at his home during the summer by the Auxiliary and the Society.

Dr. Boucher proposed that the society take a stand relative to the examination of persons under the influence of alcohol when called upon to do this at Police Headquarters. The matter will be taken up at the next regular meeting.

The meeting adjourned at 11 p.m.

A buffet luncheon was served to the 27 members present.

Respectfully submitted,

EMIL KASKIW, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 1, 1951. The meeting was called to order by the President, Dr. Louis I. Kramer, at 8:30 p.m.

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 600

With the approval of the members present the reading of the minutes of the previous meeting was omitted in view of the fact that they had already been published in the RHODE ISLAND MEDICAL JOURNAL.

The Secretary reported communications announcing the Fourth Annual Dr. Isaac Gerber Oration to be delivered at the Medical Library on Thursday, November 1, announcing a labor-management forum under the auspices of the Social Action Institute of the Diocese of Providence, to be held on October 14, and announcing the plans for the New England Postgraduate Assembly to be held at Boston, November 7, 8, and 9.

Report of the Executive Committee

The Secretary reported for the Executive Committee as follows:

At a recent meeting the Executive Committee took the following action:

Approved of the nomination by the President of Dr. Barrito Mongillo to the Governor of Rhode Island as a representative of the Association to serve on the Advisory Committee to the state Commission on Alcoholism.

* * *

Voted to issue a certificate of membership to new members elected to the Association, to be awarded at the meeting subsequent to the one at which they are elected, and also voted to request the Rhode Island Medical Society to establish an orientation course for new members of the various district societies on such subjects as malpractice, medical organization, public relations and ethics, and how to read and understand insurance policies.

* * *

Received and placed on file the report of the Treasurer regarding the annual dinner of the Association held in June.

* * *

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Voted that a survey of the membership be conducted by mail to determine the prevailing fees charged for examinations and for home, office and hospital visits in order that this information may be furnished to the Committee on Medical Economics of the R. I. Medical Society which is undertaking a study of physicians fees.

* * *

Referred to the Committee on Public Relations a communication from the Bureau of Health Education of the American Medical Association relative to television programs.

* * *

Voted to recommend to the Association that the May meeting in 1952 be eliminated in order to avoid a conflict with the Rhode Island Medical Society meeting which will be held on the 6, 7, and 8 of May.

* * *

Approved of the offer of the executive office to address envelopes for the division of weights and measures of the City of Providence offering the services of the division for checking scales in physicians offices at a minimum fee.

* * *

It was moved to accept the report of the Executive Committee and adopt the recommendation relative to omitting the May meeting in 1952.

Appointment of Committees

Dr. Louis I. Kramer announced that the appointment of obituary committees is as follows:

To prepare the tribute for the late Dr. C. E. V. Kennon:

Drs. Louis I. Kramer and Robert G. Murphy
To prepare the tribute for the late Dr. Alvah H. Barnes:

Drs. Frederic J. Burns and Michael DiMaio
To prepare the tribute for the late Dr. Edward J. Black:

Drs. Frank Cummings and Parker Mills

Announcements by the President

Dr. Kramer reported an invitation to the membership to attend a seminar on rehabilitation to be held at the Medical Library on November 3.


He also reported on plans for the November meeting of the Association and urged members to reserve the date for attendance.

Dr. Kramer also called attention to the notice sent to the membership by the Rhode Island Medical Society offering a group plan for Physicians Service and Blue Cross, and he urged support of the program.

Nominations for Election to Membership

The Secretary reported that the Executive Com-

continued on page 604



stress

Stress, common to severe infections, to surgery and burns, increases demands upon adrenal cortical function. When adrenal cortical function is taxed beyond and recovery threatened or even impaired, impeded by inadequacy of output.

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by subcutaneous, intramuscular or intravenous injection.

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 602

mittee recommends for election to active membership the following: Donald F. Larkin, M.D., H. Raymond McKendall, M.D., Francis L. McNelis, M.D., Pasquale J. Pesare, M.D., and for election to associate membership: Charles B. Round, M.D.

It was moved that these physicians be elected to membership. The motion was seconded and adopted.

Dr. Kramer spoke briefly on the proposal of the Executive Committee to award membership certificates to new members and also to have them introduced at the meeting subsequent to their election by one of their sponsors.

Scientific Program

Dr. Kramer introduced as the first speaker of the evening Dr. Nathan Chaset, of Providence, Surgeon, Department of Urology, Rhode Island Hospital, who spoke on "Nephrectomy for Tuberculosis."

After a few preliminary remarks about the treatment of renal tuberculosis with streptomycin, Dr. Chaset described a new surgical technique for nephrectomy in the presence of renal tuberculosis. The usual lumbar incision is made and the infected kidney is carefully exposed and isolated from its bed and pulled out through the incision without any detachment from its pedicle. The wound is then closed and dressed. The kidney is then removed. He has found that this technique obviates the spilling of infected urine into any part of the wound or abdominal structures, that is, all the infected material is channeled outside. He has had uniformly good results in the six cases that have been subjected to this type of surgery.

The same surgical procedure can be used for the treatment of infected ureters.

Dr. Chaset's paper was discussed by Dr. Vincent Oddo who told of his experiences with streptomycin in the treatment of early tuberculosis of the kidney at the Wallum Lake Sanatorium.

Dr. Kramer announced that Dr. Norman J. Wilson, M.D., of Boston, Massachusetts, Associate of Richard H. Overholt, M.D., was ill and therefore Dr. William B. O'Brien, Superintendent of the State Sanatorium would present the paper on "Surgery for Pulmonary Tuberculosis in Rhode Island", and that Dr. Walker, a member of Dr. Overholt's staff would discuss the paper.

Dr. O'Brien stated that there was an increase in the surgical treatment of tuberculosis as a definitive measure. He made it clear that resection (pneumonectomy, lobectomy, segmental resection) of the involved part was the treatment of choice in primary tuberculosis.



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Dr. O'Brien also discussed the results of extra-pleural plombage thoracoplasty in pulmonary tuberculosis. Results of the surgical treatment of tuberculosis at Wallum Lake were as follows:

| | <i>Cured</i> | |
|------------------|--------------|-------|
| Unilateral | 72 | (89%) |
| Bilateral | 8 | (42%) |

Advantages of plombage thoracoplasty were listed as follows:

- 1) No sign deformity
- 2) Entire collapse at one stage
- 3) No sign paradox
- 4) Less physical and mental strain
- 5) Short surgical progress

Potential dangers of plombage thoracoplasty:

- 1) Infection
- 2) Pressure necrosis
- 3) Migration of spheres (between ribs, intra-thorax)

Dr. O'Brien's paper was discussed by Dr. Walker who considered the results of the treatment of tuberculosis at the Wallum Lake Sanatorium as excellent. Reasons for the excellent results were given as follows:

- 1) Excellent teamwork
- 2) Advent of streptomycin and paramino salicylic acid which made surgery a less dangerous procedure.

The final speaker was Dr. Donald S. King of Boston, Massachusetts, Area Consultant in Tuberculosis, U. S. Veterans Administration, who spoke on "Should We Try to Cure Tuberculosis by Cutting Out the 'Rotten Spot'? The Medical Viewpoint."

Dr. King's remarks made it clear that it was more reasonable to him to remove the infected area or material in a tuberculosis lung than to compress it by the several methods that are in use. He advocated prolonged use of antibiotic treatment until maximum improvement, then surgical treatment.

His paper was discussed by Drs. Ham, Corsello, Beardsley and Reimer.

The meeting adjourned at 10:40 p.m.

Collation was served.

Attendance was 110.

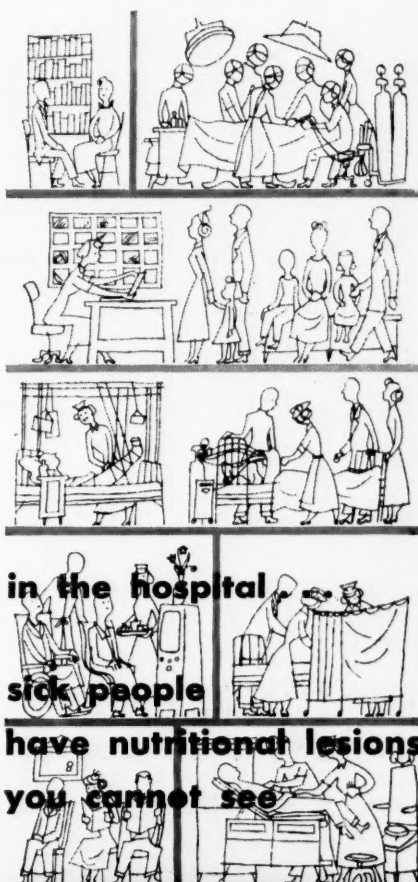
Respectfully submitted,

MICHAEL DiMAIO, M.D., *Secretary*

NEXT MEETING . . .

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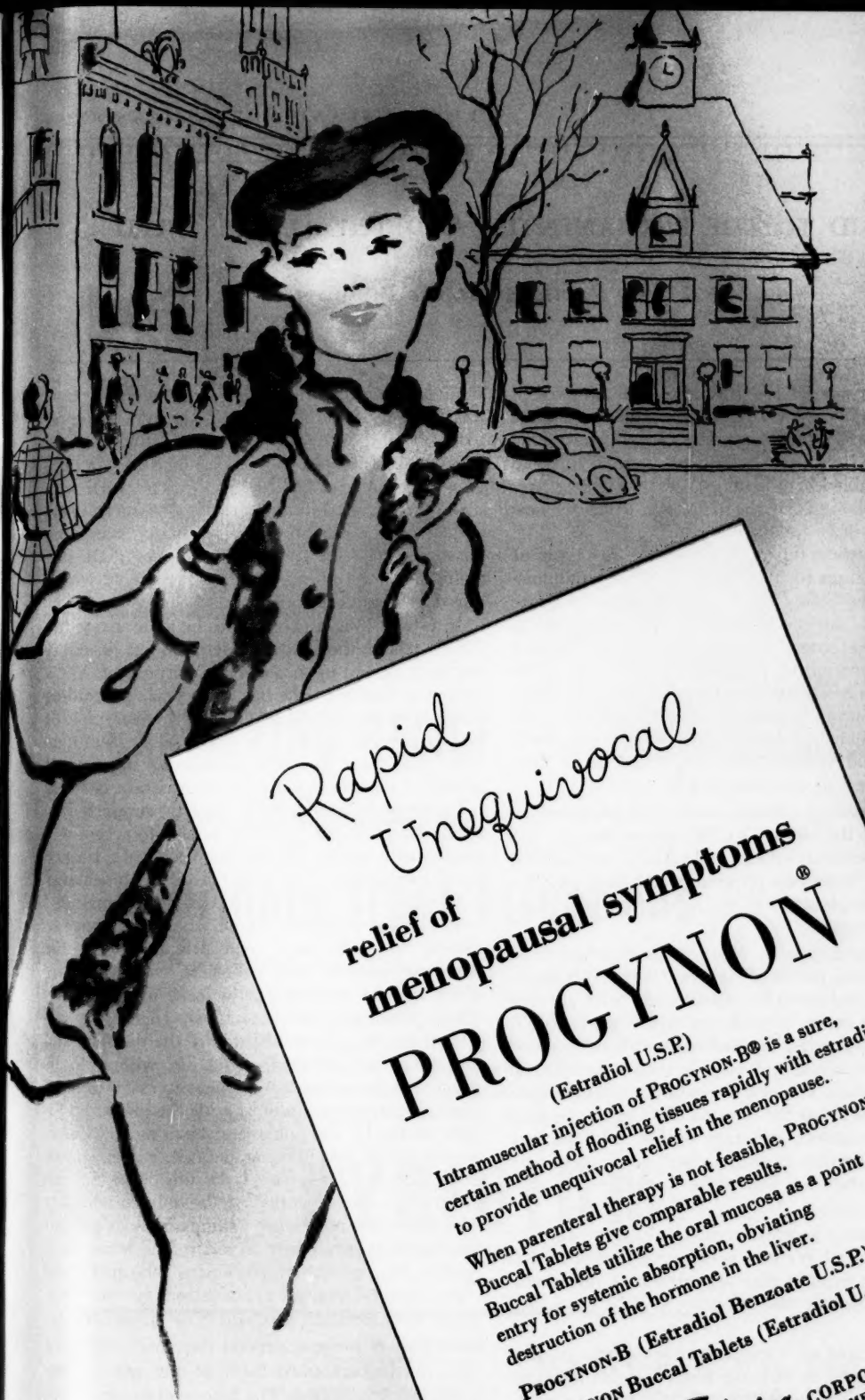
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| Riboflavin | 5 mg |
| Niacinamide | 150 mg |
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COMPONENT SOCIETIES BY MEDICAL DISTRICTS — 1951

| SOCIETY | DELEGATES | COUNCILLOR | OFFICERS | MEETING |
|--------------------------------------|---|--|--|---|
| Kent County Medical Society | Rocco Abbate Peter Erinales | Arthur Hardy | <i>President</i> , Jean M. Maynard <i>Vice Pres.</i> , Edmund T. Hackman <i>Secretary</i> , Jeannette E. Vidal <i>Treasurer</i> , John A. Mack | 3rd or 4th Tuesday of each month |
| Newport County Medical Society | Frank Logler Donald B. Fletcher | Samuel Adelson | <i>President</i> , Henry W. Brownell <i>1st Vice Pres.</i> , Robert L. Bestoso <i>2nd Vice Pres.</i> , John M. Malone <i>Secretary</i> , Osmond Grimes <i>Treasurer</i> , Norbert Zielinski | 4th Tuesday of every other month, starting September |
| Pawtucket Medical Association | James P. Healey Henry J. Hanley Henry E. Turner Edward E. Turner Edward E. Trainor Duncan H. C. Ferguson | Earl J. Mara | <i>President</i> , Kieran Hennessey <i>Vice Pres.</i> , Laurence Senseman <i>Secretary</i> , Hrad H. Zolman <i>Treasurer</i> , Harold A. Woodcome | 3rd Thursday of every month |
| Washington County Medical Society | Louis Morrone Samuel Nathans | John P. Jones | <i>President</i> , Albert C. Henry <i>Vice Pres.</i> , Julianna Tatum <i>Secretary</i> , Samuel Farago <i>Treasurer</i> , Samuel Farago | 2nd Wednesday of every 3 months, starting Oct. |
| Bristol County Medical Association | John A. Mellone | Paul Bruno | <i>President</i> , Samuel Clark <i>Vice Pres.</i> , Arcadie Giura <i>Secretary</i> , Paul Bruno <i>Treasurer</i> , Robert Drew | 3rd Tuesday of each month |
| Woonsocket Medical Society | Victor H. Monti Saul Wittes | Leo Dugas | <i>President</i> , Alfred King <i>Vice Pres.</i> , G. A. Crepeau <i>Secretary</i> , Emil Kaskiw <i>Treasurer</i> , Paul Boucher | No fixed date |
| Providence Medical Association | Charles J. Ashworth Robert Baldridge J. Murray Beardsley Frederic J. Burns Francis H. Chafee Peter P. Chase Frank B. Cutts Harry E. Darrah | Frank Dimmitt | <i>President</i> , Louis I. Kramer <i>Vice Pres.</i> , Frederic J. Burns <i>Secretary</i> , Michael DiMato <i>Treasurer</i> , Robert G. Murphy Herman Grossman Peter Harrington William Horan Russell Hunt Louis I. Kramer Edward McLaughlin Daniel Troppoli | 1st Monday of every month; Oct.-May inclusive Robert Murphy John Myrick J. C. O'Connell E. O'Reilly A. L. Potter Louis Sage George W. Waterman |
| Rhode Island Medical Society 1951-52 | <i>President</i> , Herman A. Lawson <i>Vice Pres.</i> , Edward S. Cameron <i>Pres. Elect.</i> , Albert H. Jackvony <i>Secretary</i> , Morgan Cutts <i>Treasurer</i> , Earl F. Kelly <i>Asst. Treas.</i> , John A. Dillon | ANNUAL MEETING May 13, 14, 15, 1952 at Rhode Island Medical Society Library, 106 Francis Street Providence 3, R. I. | CHAIRMAN, STANDING COMMITTEES Peter P. Chase Charles L. Farrell James H. Fagan Marshall Fulton Nathan Chaset Stanley Sprague Irving A. Beck John E. Donley Robert T. Henry John P. Jones | Scientific Work and Annual Meeting Public Policy and Relations Public Laws Postgraduate Education Medical Economics Industrial Health Library Publications Auditors |



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AID TO THE PERMANENTLY AND TOTALLY DISABLED

— A New Public Assistance Program —

IN THIS ISSUE of the JOURNAL is an excerpt from Public Law 734, which explains that the Federal Government recognizes a need for specific financial aid for persons who are permanently and totally disabled. The sections 1401-1405 here presented explain clearly the manner in which the new program will be conducted.

At the present time in R. I. we have two types of relief programs for the needy. The first is administered by the State Department of Social Welfare from funds supplied jointly by the State and the federal government. The financial support from the federal government is granted only if the State program is conducted according to rules and regulations set up in Washington, such as stated in the excerpt published below. Accordingly all needy persons and families are categorized as to their specific need, or condition in life.

The categories already established are listed as, (a) Aid to the blind; (b) Old age assistance; (c) Aid to dependent children; (d) Aid to the disabled. This latter is the new program which has prompted this brief explanation of the modus operandi relating to the needy.

The second type of relief program which is in operation here is that of General Public Assistance. This is administered by local city and town governments with money provided jointly by the local and the state treasuries. The persons and families aided by this program are not eligible for the federal and state program. The new law will permit many persons who are now the responsibility of the General Public Assistance program to fall into the new category and thus have their financial burdens paid in part by state and federal funds, rather than state and local funds.

A statement recently received from the Department of Social Welfare is herewith quoted in part to further explain that organization's interpretation of how the new program will be conducted here.

"The intent of Congress as set forth in committee reports, is to make federal funds available to states (1) to provide public assistance to needy persons who, at point of application for assistance, are medically and socially unable to plan for employment or training, and (2) who assure a con-

tinuing redetermination of need, of mental or physical disability, and of capacity, or lack of it, to prepare for, and take, employment or training. Congressional committee reports emphasize the obligation of public assistance agencies to work with medical care, rehabilitation, and other practitioners and agencies toward the end of assuring maximum possible service for study and treatment of the disability and for training and/or employment within any developing capacity of the patient.

In establishing a program to be administered in Rhode Island, the following definition of disability has been agreed upon. 'For the purpose of AD, a person is disabled if he has a physical, (excluding blindness) or mental, (excluding the condition of feeble-mindedness when it exists alone, with no other physical or mental involvement,) impairment which (1) medical findings demonstrate is likely to continue; (2) is of such severity, supported by social data, that the person is unable to accept any employment within his competence, to be trained for any employment, or in the case of a homemaker to be unable to carry out her duties of homemaking.'

Physicians in Rhode Island who give service in clinics, hospitals, their own private offices, the homes of patients and elsewhere will be having direct contact with this new form of assistance. Those physicians who are actively treating an applicant for, or recipient of, aid to the disabled and those who are selected — and are willing to be selected — by patients for the necessary general medical examination will provide the medical findings needed for the public assistance agency determination that disability, as defined, exists, in any given patient. The role of the physicians in this program is similar to that of the ophthalmologists who make and report eye examinations as part of the eligibility procedure in aid to the blind. It is similar, too, to that of physicians who make and report general medical examinations in the Vocational Rehabilitation program. The physician's examination is to be a general one, with reporting only, on the prescribed form, of any special diagnostic work indicated. The form will be sent to the physician by the social worker after prior planning with the applicant for, or recipient of, aid to the disabled. The report form will be returned by the

continued on page 610



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AID TO DISABLED

continued from page 608

physician to the social worker at the address specified on the form. The physician will submit his bill on a form provided by the Division of Public Assistance to the central office at 40 Fountain Street, Providence, Rhode Island. The Division of Public Assistance will pay \$5 directly to the private physician who submits a report and who had to make an examination for this purpose. Two dollars will be paid to the private physician who prepares the report from current records in his file. The report forms will be reviewed by an administrative team composed of a physician, a rehabilitation counsellor, a social worker qualified by training and experience, and an administrative staff member of the Division of Public Assistance. The physician and social worker are expected to be on the staff of the State Department of Health. The Vocational Counsellor is expected to be on the staff of the Office of Vocational Rehabilitation in the State Department of Education. The team will determine if the findings are complete and adequately enough documented to determine if disability, as defined, is present. If findings are not sufficient, the team will determine what steps are to be taken to obtain the information needed. To determine that disability, as defined, must exist, the medical findings must be complete enough to show that there is a specific physical or mental (other than mental deficiency alone) impairment from which no recovery can, at a given point, be expected; the social findings must be complete enough to show that there is, at a given point, no capacity to engage in any useful work in or out of the home, in remunerated employment or as a homemaker, or to engage in training.

The inter-dependence of medical and social findings in the determination of eligibility for aid to the disabled may be illustrated by the following: A patient, with epilepsy, may be found incurable, but with seizures which are controllable. If he lives in a community in which there is employment for which he has actual or potential capacity, and if an employer is willing to employ him with this kind of disability, he is ineligible for aid to the disabled. If no employer in the fields in which the patient has actual or potential capacity, is willing to hire an epileptic, the patient, if in need and otherwise eligible, is eligible for aid to the disabled.

Aid to the Disabled payments cannot be made to or in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual (a) who is a patient in an institution for tuberculosis or mental diseases, or (b) who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof. Aid to the Disabled payments cannot be made under the present plan, to,

RHODE ISLAND MEDICAL JOURNAL

or in behalf of, persons eligible for old age assistance, or aid to the blind, or to persons 18 years of age or younger."

COMMITTEE ON SOCIAL WELFARE

— *Report to the House of Delegates,
September 26, 1951* —

Your committee has had several meetings with the officials of the State and Local Public Welfare Agencies.

We requested more adequate fees and direct payment by the State Welfare Agencies for services rendered patients under their supervision. The public officials pointed out that until October 1, 1950 when a special amendment to the Public Assistance Act was passed it was impossible to pay the doctor directly. They assured us that since it is now legally proper to give direct payment that they will work out a plan to do so. They are still opposed in principle to this change, but will accede to our request as soon as details can be worked out.

As regards fees they again state that they are unable to meet our previous requests but have agreed to pay five dollars for emergency night calls from 7 P.M. to 7 A.M., three dollars for an office visit, and four dollars for a house visit. Your committee accepted this schedule for the present, subject to the approval of the House of Delegates, but urged the administrators to be more realistic in their future plans for physician fees.

These agreements were reached at meetings held in July. To date, the mechanism for carrying them out has not been established by the Welfare Agencies. In a recent communication to this committee, Miss Elizabeth Smith, Acting Administrator of Public Assistance gave assurance that steps are being taken to accomplish this.

We would like to bring to your attention the plan which the welfare agencies are now trying to develop for what they consider better handling of the financial aspects of medical care granted Public Assistance recipients. They are exploring the possibility of setting up a compulsory medical plan, also called a "pooled funds plan." Under this a certain sum of money would be paid into a pooled fund for each person receiving public assistance. From this fund all medical care expenses would be paid, including hospitalization, medicine, appliances, physicians' fees etc.

This idea has caught the fancy of the various administrators who believe this is the only solution to the problem of the cost of medical care to relief recipients. They express the opinion that we as doctors should not object since under this plan we would be sure of our money. It is very difficult to tell them we are not interested in money, since that has been the main theme of our conferences for the past year.

continued on page 616



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The stillness of water, the peace, the deep repose.

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EXCERPT FROM PUBLIC LAW 734 — 81ST CONGRESS

Title XIV — Grants to States for Aid to the Permanently
and Totally Disabled*"Appropriation"*

"Sec. 1401. For the purpose of enabling each State to furnish financial assistance, as far as practicable under the conditions in such State, to needy individuals, eighteen years of age or older who are permanently and totally disabled, there is hereby authorized to be appropriated for the fiscal year ending June 30, 1951, the sum of \$50,000,000, and there is hereby authorized to be appropriated for each fiscal year thereafter a sum sufficient to carry out the purposes of this title. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Administrator, State plans for aid to the permanently and totally disabled.

*"State Plans for Aid to the Permanently and
Totally Disabled"*

"Sec. 1402. (a) A state plan for aid to the permanently and totally disabled must (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them; (2) provide for financial participation by the State; (3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan; (4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for aid to the permanently and totally disabled is denied or is not acted upon with reasonable promptness; (5) provide such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Administrator shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Administrator to be necessary for the proper and efficient operation of the plan; (6) provide that the State agency will make such reports, in such form and containing such information, as the Administrator may from time to time require, and comply with such provisions as the Administrator may from time to time find necessary to assure the correctness and verification of such reports; (7) provide that no aid will be furnished any individual under the plan with re-

spect to any period with respect to which he is receiving old age assistance under the State plan approved under section 2 of this Act; aid to dependent children under the State plan approved under section 402 of this Act, or aid to the blind under the State plan approved under section 1002 of this Act; (8) provide that the State agency shall, in determining need, take into consideration any other income and resources of an individual claiming aid to the permanently and totally disabled; (9) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of aid to the permanently and totally disabled; (10) provide that all individuals wishing to make application for aid to the permanently and totally disabled shall have opportunity to do so, and that aid to the permanently and totally disabled shall be furnished with reasonable promptness to all eligible individuals; and (11) effective July 1, 1953 provide, if the plan includes payments to individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions.

(b) The Administrator shall approve any plan which fulfills the conditions specified in subsection (a), except that he shall not approve any plan which imposes, as a condition of eligibility for aid to the permanently and totally disabled under the plan—

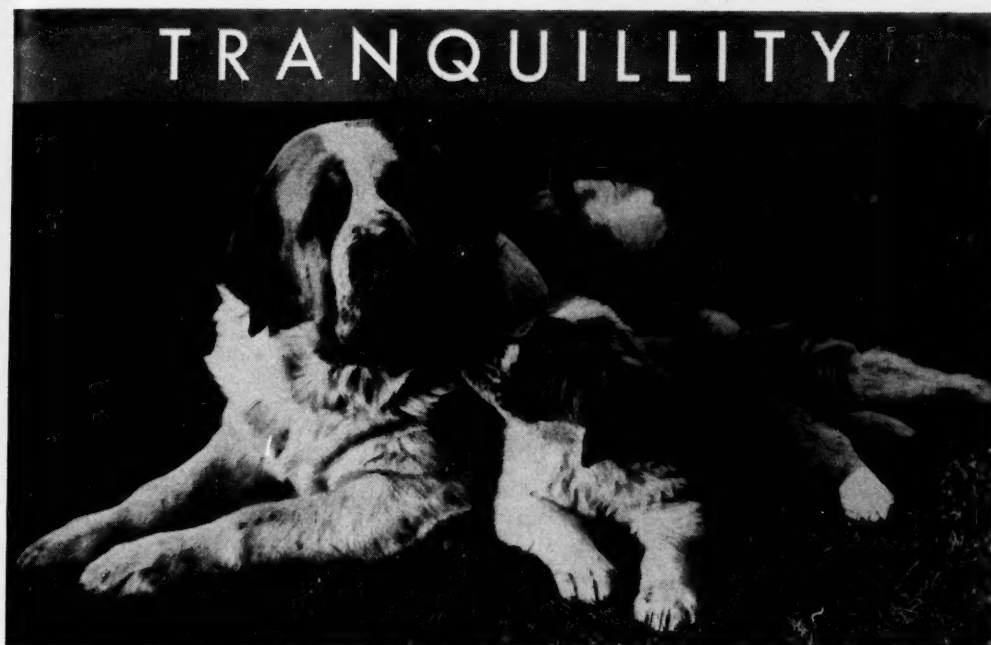
"(1) Any residence requirement which excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for aid to the permanently and totally disabled and has resided therein continuously for one year immediately preceding the application;

"(2) Any citizenship requirement which excludes any citizen of the United States.

"Payment to States"

"Sec. 1403. (a) From the sums appropriated therefor, the Secretary of the Treasury shall pay to each State which has an approved plan for aid to the permanently and totally disabled, for each quarter, beginning with the quarter commencing October 1, 1950, (1) in the case of any State other than

continued on page 614



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EXCERPT FROM PUBLIC LAW 734

continued from page 612

Puerto Rico and the Virgin Islands, an amount, which shall be used exclusively as aid to the permanently and totally disabled, equal to the sum of the following proportions of the total amounts expended during each quarter as aid to the permanently and totally disabled under the State plan, not counting so much of such expenditure with respect to any individual for any month as exceeds \$50—

“(a) three-fourths of such expenditures, not counting so much of any expenditure with respect to any month as exceeds the product of \$20 multiplied by the total number of such individuals who received aid to the permanently and totally disabled for such month, plus

“(b) one-half of the amount by which such expenditures exceed the maximum which may be counted under clause (a);

and (2) in the case of Puerto Rico and the Virgin Islands, an amount, which shall be used exclusively as aid to the permanently and totally disabled, equal to one-half of the total of the sums expended during such quarter as aid to the permanently and totally disabled under the State plan, not counting so much of such expenditure with respect to any individual for any month as exceeds \$30; and (3)

RHODE ISLAND MEDICAL JOURNAL

in the case of any State, an amount equal to one-half of the total of the sums expended during such quarter as found necessary by the Administrator for the proper and efficient administration of the State plan, which amount shall be used for paying the costs of administering the State plan or for aid to the permanently and totally disabled, or both, and for no other purposes.

“(b) The method of computing and paying such amounts shall be as follows:

“(1) The administrator shall, prior to the beginning of each quarter, estimate the amount to be paid to the State for such quarter under the provisions of subsection (a), each estimate to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsection, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, (B) records showing the number of permanently and totally disabled individuals in the State, and (C) such other in-

continued on page 616

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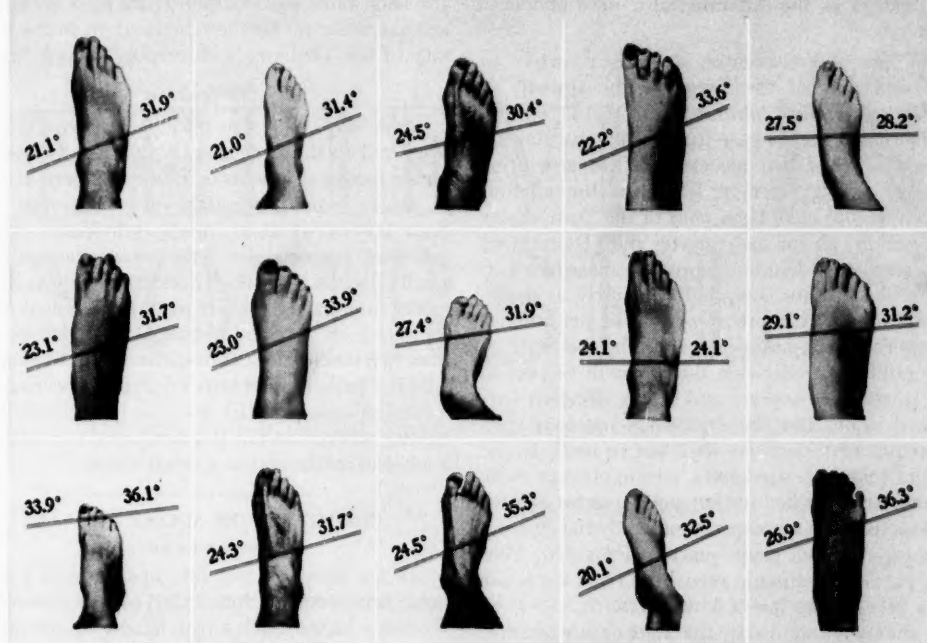
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1. Ready, W. J.: J. of Lab. & Clin. Med. 37:365 (March) 1951.

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EXCERPT FROM PUBLIC LAW 734

continued from page 614

vestigation as the Administrator may find necessary.

"(2) The Administrator shall then certify to the Secretary of the Treasury the amount so estimated by the Administrator, (A) reduced or increased, as the case may be, by any sum by which he finds that his estimate for any prior quarter was greater or less than the amount which should have been paid to the State under subsection (a) for such quarter and (B) reduced by a sum equivalent to the pro rata share to which the United States is equitably entitled, as determined by the Administrator, of the net amount recovered during a prior quarter by the State or any political subdivision thereof with respect to aid to the permanently and totally disabled furnished under the State plan, except that such increases or reductions shall not be made to the extent that such sums have been applied to make the amount certified for any prior quarter greater or less than the amount estimated by the Administrator for such prior quarter: Provided, That any part of the amount recovered from the estate of a deceased recipient which is not in excess of the amount expended by the State or any political subdivision thereof for the funeral expenses of the deceased shall not be considered as a basis for reduction under clause (B) of this paragraph.

"(3) The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Treasury Department, and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Administrator, the amount so certified.

"Operation of State Plans

"Sec. 1404. In the case of any State plan for aid to the permanently and totally disabled which has been approved by the Administrator, if the Administrator after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of such plans, finds—

"(1) that the plan has been so changed as to impose any residence or citizenship requirement prohibited by section 1402 (b), or that in the administration of the plan any such prohibited requirement is imposed, with the knowledge of such State agency in a substantial number of cases; or

"(2) that in the administration of the plan there is a failure to comply substantially with any provision required by section 1402 (a) to be included in the plan:

the Administrator shall notify such State agency that further payments will not be made to the State

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until he is satisfied that such prohibited requirement is no longer so imposed, and that there is no longer any such failure to comply. Until he is so satisfied he shall make no further certification to the Secretary of the Treasury with respect to such State.

"Definition

"Sec. 1405. For the purposes of this title, the term 'aid to the permanently and totally disabled' means money payments to, or medical care in behalf of, or any type of remedial care recognized under State law in behalf of, needy individuals eighteen years of age or older who are permanently and totally disabled, but does not include any such payments to or care in behalf of any individual who is an inmate of a public institution (except as a patient in a medical institution) or any individual (a) who is a patient in an institution for tuberculosis or mental diseases, or (b) who has been diagnosed as having tuberculosis or psychosis and is a patient in a medical institution as a result thereof."

COMMITTEE ON SOCIAL WELFARE

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Such a plan was put into operation in Connecticut, but was abandoned due to a technicality in the State Laws. Such a plan is now in operation in New Hampshire. Whether this is the method by which Federal Medicine is going to be forced upon us, we cannot now discern, but, it may well be.

Your committee has tried for many years to maintain amicable relations with the State Welfare Organizations. It has recognized that these organizations have thousands of people under their supervision. These people are the poor and unfortunates who need medical care equally, if not more than their more fortunate fellow citizens. Our attitude has been, that we as doctors should furnish this care, willingly and intelligently. We have asked to be adequately reimbursed; but have not felt we could demand high fees. We still are of the opinion, as expressed before that this society should work out a plan whereby physicians are available day and night for the care of these patients, whether they are true emergencies or not. The assigning of specific physicians to designated days appears to be the best solution. With proper presentation this might be worked out voluntarily. If not, it should be worked out some other way.

Respectfully submitted,
PETER F. HARRINGTON, M.D., *Chairman*

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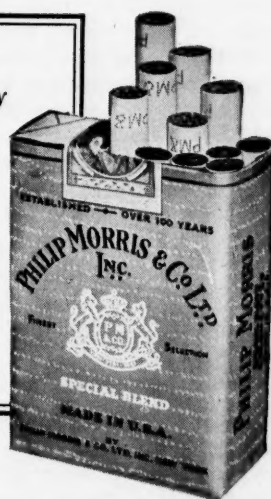
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BOOK REVIEWS

RESEARCHES IN BINOCULAR VISION by Kenneth N. Ogle, Ph.D. W. B. Saunders Company, Phil., 1950, \$7.50.

The Dartmouth Eye Institute at Hanover, New Hampshire, terminated its activities in 1947, after eighteen years of research in physiologic optics which attracted world-wide attention. The greater part of the subject matter of this book is based on Dr. Ogle's researches, and that of his co-workers, at the Institute.

The material is arranged in four parts: the organization and sensory cooperation of the two retinas; the fusional processes in binocular single vision; the problems in binocular vision when changes are made in the relative magnification of the images of the two eyes; and the experimental and theoretical bases for aniseikonia (different size and shape of ocular image seen by one eye as compared with that of the fellow eye).

The text of this monograph, with its many graphs and mathematical formulas, is inevitably difficult; nevertheless, the book is a most important contribution to physiologic optics.

MILTON G. ROSS, M.D.

FROM A DOCTOR'S HEART by Eugene F. Snyder, M.D. \$3.75. Philosophical Library, New York.

(Foreword by Dr. Paul D. White)

The author of this book is obviously a good doctor and a good man. The book, based on articles written during his recovery from an attack of acute myocardial infarction, embodies not only the thoughts and feelings of a person who is passing through a painful and dangerous illness of whose significance he is well aware, but also a background of autobiography and of personal philosophy. When urged by colleagues to write it he asked, "Shall I expose my own life?" He has, indeed, done just this—clearly, frankly and effectively. Not only has he bared his own soul in a clear statement of his reaction to his personal suffering and danger, but he has set forth the fundamentals of his thinking on science, religion and on international and interracial relations.

In addition to this in the detailed discussions between his wife, also a physician, and his son, a

highly intelligent youth with an inquiring mind, discussions in which the doctor as he went on to recovery was himself able to take part, Dr. Snyder has given clear and careful explanations of cardiovascular physiology and pathology with a discussion of neuroses and psycho-somatic medicine that are as good examples of medical instruction to the lay public as will be found anywhere in modern literature. While there may be details, such as the degree of emphasis on the emotional factor in the production of hypertension, in which there may be a difference of opinion, these are of minor account. The story of the doctor's flight from Russia and later, with his physician wife, from Czechoslovakia, of early persecution and escape and now the necessity to face personal and world problems as an American, interwoven with his account of his own reaction to his own suffering and danger is of interest to all. The physician, particularly the younger man about to enter practice, will find much that is worth while in this volume bearing on the art of medicine. To the layman, particularly he who has "heart trouble" organic, functional or purely imaginary, this book will prove of very great value.

ALEX M. BURGESS, M.D.

PRINCIPLES AND PRACTICE OF OBSTETRICS by J. P. Greenhill. Originally by Joseph B. DeLee. W. B. Saunders Company, Phil., 1951. \$12.00.

Any textbook, continuously in print for 38 years, gathers a considerable store of outdated information, procedures, and illustrations which are handed down from one edition to the next, more out of respect for the original author than for their practical or historical value. This has been true of previous editions of Dr. DeLee's book.

However in this, the 10th edition, and the third edited by Dr. Greenhill, the author has succeeded in making this the most modern textbook on obstetrics, and has come close to presenting obstetrics as it is practiced this year in our better hospitals.

Not a single page has been left as it was in the last edition and much new material has been added. Many of the old illustrations are missing and 151 new ones have appeared. The new material includes the work by Reynolds and Gillespie on uterine

physiology and growth, and Priscilla White's hormonal treatment of diabetes complicated by pregnancy. There is new data on analgesia and anesthesia, and on the treatment of threatened and habitual abortion. The present day treatment of syphilis, tuberculosis, heart disease, thyroid disorders, anemia and other illnesses are presented as they relate to obstetrics.

Last year, Drs. Nicholson Eastman, Charles McCormick, J. P. Greenhill and the late Dr. Paul Titus, all authors of popular textbooks on obstetrics met and standardized many definitions, classifications and procedures about which there had been no agreement previously. They arrived at uniform and much simplified classifications of the toxemias of pregnancy, of the types of placenta previa, and of breech presentations and their methods of delivery. Definitions of engagement and stations of the head, and of low, mid and high forceps were agreed upon.

These standardizations which are a major contribution to obstetrical teaching, are presented in this text.

The definition of mid forceps is the one found in the Williams-Stander text. This requires that the lowest part of the fetal skull shall be at the level of the ischial spines. A more conservative definition and a safer one was that proposed for so many years by DeLee. According to DeLee, the greatest diameter of the head, the biparietal, must

have reached the spines for the delivery to be a mid forceps. A "mid forceps" now becomes even more formidable since it includes many operations which we formerly classed as high forceps, that is, cases in which the biparietal diameter has not reached the level of the spines, although the lowest part of the skull has.

There is still too much emphasis on the use of the bag and of scalp traction in the treatment of placenta previa. These procedures have been abandoned in most of the best obstetrical hospitals. The author has reflected present thinking in condemning the classical Cesarean section as an elective procedure although he does devote several illustrations to it.

The time honored but practically useless taking of external pelvic measurements has been discarded in this edition.

Dr. Greenhill's textbook should certainly continue to be one of the two most popular works on obstetrics.

WILLIAM J. MACDONALD, M.D.

CLINICAL HEART DISEASE by Samuel A. Levine. 4th Edition. W. B. Saunders Company, Phil., 1951. \$7.75.

This book is a revision of a textbook of cardiology that was first published in 1936. In the preface of the first edition, the stated purpose of the

continued on next page

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author is to publish a book which will be useful to the general practitioner in the diagnosis, prognosis, and treatment of heart disease. The numerous advances in recent years in the therapy of disorders of the cardiovascular system make the publication of this revised edition timely. The newer methods of treatment such as surgery in congenital heart disease and mitral valvular disease, antibiotics in bacterial endocarditis and anticoagulants in coronary artery disease have been integrated into the discussions of these various types of heart disease.

A major revision of previous editions has been required in the section on clinical electrocardiography, and this section has been extensively revised to include a discussion of unipolar limb leads and multiple precordial leads. This section is in keeping with the remainder of the text and provides a good concise review of this subject. There is also a brief section on phonocardiography which serves to present some of the clinical applications of this method of examination.

This volume consists of the author's personal opinions on many subjects. These opinions are based on a wide practical experience, and there are many instances cited from this experience. This serves to make the book very readable and probably more useful to the practitioner than some of the more complete and encyclopedic texts on dis-

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ease of the heart. Especially interesting are his discussions of the medico-legal aspects of heart disease, acute cardiovascular emergencies and the surgical and obstetrical risk in patients with heart disease.

This new edition brings this popular text up to date and makes it a valuable volume for the student and practicing physician.

BERNARD RAPOPORT, M.D.

HANDBOOK OF NUTRITION. A symposium prepared under the auspices of the Council on Foods and Nutrition of the American Medical Association. Second Edition. The Blakiston Co., N. Y., 1951. \$4.50.

The study of man's nutritive processes has been given great impetus by the developments of World War II. In the second edition of this symposium, the results of these developments on the conception of utilization of food by man are discussed. The Council on Foods and Nutrition again fulfills its function of keeping the physicians alert to the constantly changing picture in the science of nutrition.

The contributors, covering the field of Individual Nutrients, Nutritional Needs, Nutritional Deficiencies, and Foods and their Nutritional Qualities, present a timely, easily accessible reference to the physician. While it would be impossible to go into detailed discussion of the contributions, mention is made of the Foods for Emergencies. Since communities are uniting in preparation for mass feeding in case of emergency, the lessons learned from World War II should prove of value.

The interrelation of good nutrition, agriculture, public education and world peace is stressed throughout the volume. Nutrition, too, must be treated with a global aspect.

If one article could be chosen which would accent the progress made in the study of the science of nutrition "Imbalance and Dietary Interrelationships in Nutrition" would serve the purpose. Advanced studies on the metabolism of individual food elements have proven the need for understanding the interrelationships in nutrition.

Old contributors, as well as new, in presenting newer concepts on the physiology of body fluids, carbohydrate and mineral metabolism, fat and protein utilization, and the vitamins as well as recommendations for improving the quality of cheap staple foods, fulfill the promise in the title, "Handbook of Nutrition."

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HANDBOOK OF MEDICAL MANAGEMENT by Milton Chatton, Sheldon Margen and Henry B. Brainerd, University Medical Publishers. Palo Alto, 1951. 2nd ed. \$3.00.

The form and content of the second edition of the *Handbook of Medical Management* follows that of the first edition previously reviewed (R. I. Med. Jour., May 1950). There have been a few deletions of material considered outmoded by the authors but the addition of new material has increased the volume from 453 pages to 507 pages. Although too bulky for the pocket it can conveniently be carried in the doctor's bag.

The chapter on fluid balance and electrolyte therapy has been augmented by additional text and illustrative charts, and emphasizes the physiological care of the patient. The effects of serum potassium concentration of the electrocardiogram are considered in detail. A formula for the determination of type and amount of parenteral fluids is presented. Most of the new material, however, is concerned with the use of ACTH and Cortisone, both in the chapter on hormones and under the various diseases for which these drugs may be of value. The antibiotics are treated also as a group and a comparison table of the relative pathogen sensitivity of Aureomycin, Chloromycetin and Terramycin is included.

In addition to providing an outline of specific and general measures to be carried out by the physician, the book provides useful information relative to the family care of the patient, a reminder for the physician's advice to those caring for the patient at home. The handbook succeeds in its purpose of providing a guide to the physician after the diagnosis has been established.

A. LLOYD LAGERQUIST, M.D.

PRACTICAL CLINICAL PSYCHIATRY by Edward A. Strecker, A.B., A.M., Sc.D., Litt.D., M.D.; Franklin G. Ebaugh, A.B., M.D. and Jack R. Ewalt, M.D. 7th ed. The Blakiston Company, Phil., 1951. \$7.00.

I have had the privilege of writing a review of the seventh edition of *Practical Clinical Psychiatry* by Dr. Edward A. Strecker, Dr. Franklin G. Ebaugh, and Dr. Jack R. Ewalt.

The significance of their work is contained in their own statement which has been substantiated by others that "no less than one child in every twelve is destined to need psychiatric attention in adult life and many of them will require treatment in mental public hospitals."

This book sets down the requisites of the complete doctor and emphasizes the fact that a physician can not become a complete doctor unless he has learned the lessons of psychiatry. Misuse of the word "functional" was clearly illustrated in this book.

Nowhere have I read such accounts of understandable and simplified psychopathology. The authors present in their book stimulating, vivid and informative case history presentations. A knowledge of the contents of this book is indispensable for students in psychology, members of the courts, religious orders, teaching profession and social workers.

Needless to say, it is of value to medical men, particularly those specializing in any branch of medicine.

The book offers a new trend dealing with briefer psychotherapy. They emphasize that the so-called symptomatic treatment is the treatment chiefly for the general practitioner and student. So-called causal or deep-psychotherapy usually must be reserved for the trained psychiatrist.

All those interested in alleviating suffering and of relieving both physical and mental pain should become familiar with the briefer psychotherapeutic methods. From a table and statistics offered by the authors, it was interesting to note that the percentage of recovered and improved patients is strikingly similar in all instances, although the methods of treatment differed rather sharply among the various institutions summarized. The authors commented, "It would seem to indicate that it is not the exact treatment that is so important as the skill of the therapist who is using a given method of treatment and the ability he has to understand his patients and to help the patient develop a stronger and better integrated personality in order that he may cope with the problems of the world as they affect him in his day to day living."

In this book psychological schools of thought have been reduced to a common-sense, understandable, common denominator synthesizing the important facts and omitting much of which is regarded as being hypothetical and speculative even though there is much in each school of thought which offers an apparently intelligent and scientific explanation of the genesis and dynamics of many of the normal and abnormal psychological trends.

In conclusion, I would again like to quote the authors whose sentiments coincide with mine with regard to the ideal physician. They state: "The

ideal physician is one who is not only well trained in anatomy, physiology, and bodily chemistry, but who is ever alert to the psychiatric implications of human disease. This complete physician, when he makes any examination, even such a simple one as counting the pulse, has in mind not only the possible organic implications, but also the possibility of hidden mental conflicts which are so motivating in the production of sickness.

If the loaf of medical practice is to be thoroughly leavened, the medical students must be given from the very first week in medical school the opportunity of studying all of man, and not only a hypothetical physical half. It is a consummation devoutly to be wished."

BARRY B. MONGILLO, M.D.


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